



Oral health of schoolchildren in rural Vietnam

Part V. Sweet milk consumption and high early childhood caries experience.

Tri Q Nguyen BDS, Louise B Messer MDSc, PhD, FRACDS, FICD and James A Robertson BDS, BA, MA, MPH, FICD, FADI
Melbourne Dental School, The University of Melbourne, Victoria, Australia

Corresponding Author:

Emeritus Professor LB Messer, Paediatric Dentistry, Melbourne Dental School, The University of Melbourne, 720 Swanston Street, Carlton 3010, Victoria, Australia, Ph: (03) 9341-1473, Fax: (03) 9341 1595, Email: ljbm@unimelb.edu.au

Abstract

Background: This study was carried out in association with the Rotary Australia Vietnam Dental Health Project, a humanitarian aid project that works towards improving the oral health of children in rural villages in Vietnam. We have shown previously very high caries experience and high intakes of sweet drinks and sweet foods in several of these villages. This field study investigated the oral health of preschool children in two villages (Tan Hiep and Phu Giao) with reference to sweet intakes, particularly sweet milk. **Materials and Methods:** Questionnaires on preschoolers' oral hygiene and sweet intakes (drinks, milk, foods) were completed by parents/teachers of 198, 3-5 year-olds in these villages. Children were examined (mirror, probe) under field conditions. **Results:** Caries experience was high (mean dmft \pm SD: 9.8 ± 5.3), affecting 94% of children; 81% had caries on both anterior and posterior teeth (mean dmft: 11.6 ± 4.1); 29 children had odontogenic infections, 32 had missing teeth ($m = 68$), 6 had fillings ($f = 7$). Sweet milk intake was very common (98%), consumed by 85% of children ≥ 2 /day, between meals by 83%, and before bed by 81%. Mean dmft increased with milk intake frequency (1/day: 8.8 ± 6.2 ; 2/day: 9.8 ± 5.2 ; 3/day: 10.7 ± 5.3), and with total sweet intakes (1-2/day: 7.6 ± 4.7 ; 3-4/day: 9.4 ± 5.3 ; 5-6/day: 10.0 ± 5.4 ; ≥ 7 /day: 10.8 ± 5.3). **Conclusion:** Early childhood caries experience was very high, with some cases of odontogenic infections. In these rural Vietnam villages the need for dental services and oral health promotion, which should address dietary intakes including sweet milk, continues to be very urgent.

Introduction

The Rotary Australia Vietnam Dental Health (RAVDH) Project

The Rotary Australia Vietnam Dental Health (RAVDH) Project has been reviewed previously in this series of papers.¹ This humanitarian aid project aims to improve the oral health of school children in rural villages by providing basic dental treatment and oral health promotion, establishing a tooth brushing program at the local school, and supporting acquisition of basic dental equipment at the local hospital. Other activities include professional development where dental specialists work with local staff at the National Hospital of Odontostomatology, Ho Chi Minh City, in the process of knowledge exchange. Villages visited previously by the Project were Vi Thanh (Hau Giang Province), Ben Cau (Tay Ninh Province), Tan Hiep (Kien Giang Province) and Phu Giao (Binh Duong Province) in Southern Vietnam. In 2011, the Project returned to Tan Hiep and Phu Giao.

Oral health of rural schoolchildren studied in the RAVDH Project in 2010

The oral health of rural schoolchildren aged 11-16 years in these villages was studied in association with three RAVDH Project visits in 2007-09.^{2,4} In 2010, 208 preschool children aged 2-5 years were studied with reference to their caries experience, plaque scores, oral hygiene habits, and consumption of sweet drinks, sweet foods, and water.¹ A very high caries experience was found with a prevalence of 93% and a mean dmft (\pm SD) of 6.6 (4.5). There was also a high reported consumption of sweet drinks and sweet foods. Most children reported one or more intakes per day of sweet drinks (73%)

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President's Report

Kareen Mekertichian

By the time of reading this recent edition of Synopses for 2012, I am sure you will have settled into a busy New Year, hopefully after a wonderful Festive Season which by now may seem to be in the distant past. It always amazes me how quickly the last few months of the year roll on and how chaotic our work and family juggling becomes.

It has been an extremely busy and successful 2011 for ANZSPD, with many wonderful conferences and opportunities to meet socially and update ourselves clinically for the ongoing challenges ahead. I have also had an opportunity to visit many divisions and meet many of our dedicated members and colleagues.

The highlights were the wonderful RK Hall Lecture Tour in Uluru and the hugely successful IAPD meeting in Athens. At both events, a large cohort of the ANZSPD membership and dental team were in attendance, enjoying the amazing and unique location, clinical programmes and social events. A summary of both meetings are included in this edition of Synopses and I would like to once again thank all those involved for their tireless effort and enthusiasm.

One very pleasing change on the political advocacy front has been the increasing awareness given to the priority of children's dental health within our region – but we still have a very long way to go. Unfortunately, as the disappointing statistics continue to show, we are far from winning the war on the severity of early childhood caries (EEC) and the significant morbidity associated with the high burden of dental pain and infection in especially our pre-school populations. The topic of EEC is certainly gaining further recognition and exposure. The Victorian Division of ANZSPD held a successful meeting in Bendigo recently addressing this important and challenging topic with a plan for our Queensland colleagues to host a similar event in March 2012. Clearly, this issue deserves our ongoing interest and support in an attempt to continue our struggle against the tide of an ever-increasing and unmet decay burden.

Emeritus Professor Louise Brearley Messer AM

It is with great delight that we also welcome the New Year with the news of Professor Louise Brearley Messer's wonderful achievement in the Australia Day 2012 Honours List. Professor Brearley Messer has been honoured with the Member of the Order of Australia – granted for service to dentistry, particularly in the field of paediatric dentistry, as a clinician, academic and researcher. There are a countless number of ANZSPD members, students, colleagues and patients across Australasia and beyond - who have been directly influenced and guided by Louise's dedication and devotion to her chosen field.

It is with great pleasure that I pass on all our heartfelt thanks and congratulations to "Prof" in receiving this award for her tireless and inspired role in paediatric dentistry over many years.

I look forward to a formal opportunity later this year to recognise and celebrate this achievement more appropriately with Prof LBM and all ANZSPD members.

Paediatric HIV

Recently, a new parent at my practice challenged me on the inclusion of HIV status on our standard medical history questionnaire for her children. It got me thinking more closely on exactly what our current understanding of paediatric HIV infection is within ANZ and whether in fact, this is a legitimate health question for our particular cohort of children.

There are now more than 17,000 people with HIV infection in Australia, with approximately 1000 people newly infected each year. Fortunately, the life expectancy of people with HIV infection is increasing as improved antiretroviral treatments enable people to live longer, often decades following HIV infection. However, in 2008, 24 people in Australia still died following an acquired immunodeficiency syndrome (AIDS) diagnosis.

Data relating to the paediatric cases is a little more limited although the Australian Paediatric Surveillance Unit is responsible for monitoring communicable and vaccine preventable diseases nationally. The obvious mode of infection for children is via vertical transmission particularly at birth, from a high risk mother. Children, particularly those infected in utero who are very sick as infants can often have greater mortality rates and shortened survival times - so the emphasis is on prevention of infection and prophylaxis after birth with intensive drug regimes. Children who survive HIV in infancy generally lead to have mortality rates similar to adults and with treatment, have a very good prognosis. In 2006, 14 cases of perinatal exposure were reported in Australia with 11 mothers diagnosed pre-natally and 3 mothers post-natally – two of whom were migrants for sub-Saharan Africa. This can be contrasted with British statistics (2005) of around 750 HIV infected children, with a very large proportion of these born in, or whose parents come from sub-Saharan Africa.

The large proportion of children living with HIV infection in Australia are now entering adolescence and a range of complex care and support issues are being faced. These include adherence to drug therapies and regimes as well as questions surrounding disclosure, independence, lifestyle and freedom of choice.

Understandably, very passionate debate now revolves around the pros and cons of the possibility of universal ante-natal screening of all pregnant women – which I understand does currently occur in parts of NZ.

In Australia, in 2008, among cases of newly acquired HIV infection, male homosexual contact was reported in 86% of cases, heterosexual contact in 10% of cases, injecting drug use in 1% of cases with undetermined exposure in 3%.

Although paediatric cases of HIV infection are very uncommon, it is still imperative to remain vigilant as to the risk factors for transmission and the

obvious clinical implications which still remain for this group.

Final thoughts

Once again, I would like to thank the hard working ANZSPD executive team for another busy year and look forward to meeting many of you again in 2012. The next Biennial ANZSPD Conference will be held in Canberra (20-21 July 2012) where "ANZI" will make a return to our shores. This event will be a great opportunity to indulge in the delights of the snowy Winterland of the ACT - with an inspired clinical programme, together with fabulous social events.

Kareen Mekertichian
Federal President ANZSPD



New Zealand Branch President's Report

Mary Anne Costello

2011 has been quite a year with many distractions from Mother Nature but our members seem to be moving along quite easily

There were at least 10 of our members who participated in the Athens IAPD meeting. We all enjoyed the journey and attractions. It was also humbling to note the contribution ANZSPD had made to this conference and the recognition given to ANZSPD. Our thank you extends to those involved.

Our NZ Branch Study Day was held in Wellington on Saturday November 19. Our keynote speaker was psychologist Dr Linda Jones speaking on the 'Dental Jungle Safari or where dental psychology

can take you'. Supporting speakers were Dr Heather Keall on Cleft lip and palate 'What we know about it', Dr Erin Mahoney will speak on Maternal and Child Oral Health- two years on' and six current paediatric dentistry postgraduate students will also be presenting.

We are pleased to hear that the Otago University Dental School is in for a significant upgrade. Its facilities have been too cramped for many years

We hope that all members enjoyed a good festive season and we look forward to a quieter 2012 – Mother Nature wise.

Mary Anne Costello
President New Zealand Branch
ANZSPD



Federal Secretary-Manager's Report

Alistair Devlin

Elsewhere in this edition there are notices of a couple of important events in the Federal A.N.Z.S.P.D. Calendar. These are the Colgate Post-graduate Research Project Competition which will be held at the Convention in Canberra and secondly, the A.N.Z.S.P.D. Grant.

The Society will be conducting the two annual Louise Brearley Messer A.N.Z.S.P.D. Essay Competitions again in 2012, one for post-graduates, the other for under-graduates. The chosen post-graduate topic for 2012 is:

"Discuss the philosophy of minimally invasive dentistry and the application of minimally invasive techniques in the paediatric and adolescent dental patient"

The under-graduate topic is:

"Discuss high risk behavioural factors in adolescents which can contribute to increased decay burden for these young patients"

The Federal Council of the Society will meet at the time of the Canberra Convention, and of course, there will be the Annual General Meeting of the Society there also. I look forward to meeting up with many of you there.

Alistair Devlin
Federal Secretary-Manager ANZSPD

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and sweet foods (72%). Most consumed these between meals: sweet drinks (63%), and sweet foods (62%). There was also a high caries experience for those who reported none or low sweets consumption; 60% of children reporting no sweet drink intake had caries on both anterior and posterior teeth; 75% of those reporting no sweet food intake had caries on both anterior and posterior teeth. Assuming intakes were reported factually, it was suggested that cariogenic factors other than sweet drinks and sweet foods may be involved.¹

Sweet milk consumption

Consumption of sweet milk has been shown to be high in both developed and developing countries. A study of Spanish children showed that sugared milk and sweetened dairy products were consumed 16.4 times/week on average,⁵ the reported consumption of sweet milk by a group of pre-school children in Cambodia was 62%,⁶ and the consumption of sugared milk or sugared tea by children of similar age in Jordan was 85%.⁷ The relationship between sweet milk and early childhood caries (ECC) appears variable; some studies suggest that there is no significant relationship between sweet milk consumption and caries experience.^{5,7} However, one of these studies investigated a low caries risk population.⁵ Conversely, a study of children in Riyadh, Saudi Arabia, showed that those with a high dmft (≥ 8) and caries-free children differed significantly in their consumption of sweet milk.⁸ Differences in mean dmft have been reported also among children in Vientienne, Lao PDR, between those who consumed sweet milk compared with non-sweetened milk (6.6 vs 4.2).⁶

Anecdotes and on-site observations in Tan Hiep and Phu Giao in Vietnam suggest that sweet milk is a popular drink for parents to give young children in these villages. The aim of the present study was to investigate oral health of preschool children with reference to sweet intakes and of sweet milk in particular.

Materials And Methods

The Rotary Australia Vietnam Dental Health (RAVDH) Project 2011

As part of the RAVDH Project 2011, two teams visited Tan Hiep and Phu Giao to provide basic dental treatment and oral health promotion. Each team consisted

of two dentists, three dental assistants, one dental student, an interpreter and staff from the National Hospital of Odontostomatology, Ho Chi Minh City. Each team spent one week in both villages. Children were screened by the local dentist who selected those deemed in greatest need of treatment for the RAVDH project. Early in each clinical session, children were triaged and teeth were categorised as needing restoration, fissure sealant or extraction. A few symptomatic teeth were extracted. Only weakened enamel and carious dentine at the surface of carious lesions were removed; caries towards the pulp was left to avoid exposure. Glass-ionomer cement (Fuji IXTM, GC Asia Dental Pty Ltd, Singapore) was used to restore cavities and as a fissure sealant. A few anterior teeth were restored with resin composite.

The present study was conducted in association with the RAVDH Project 2011. Accompanied by local hospital staff, author TQN visited one kindergarten (re-visiting those visited in 2010) in each village during the week the team spent working in the village.

Study sample

With study approval from the Ethics Committee of the University of Melbourne, plain language statements, consent forms and questionnaires were given to the kindergarten principals, who provided approval for the study and gave the consent forms to parents to sign. Child consent was indicated by their participation in the examination. A total of 198 children aged 3-5 years participated. The study sample was limited by the time spent at each village.

Questionnaire

A 21-item questionnaire in Vietnamese containing choices and open-ended questions was used to collect data on each child using the same questions as in the previous study.¹ Questions were added addressing milk intake: sweetness, type, brand, frequency and time of consumption. In Tan Hiep, teachers completed the questionnaires, answering the questions according to their knowledge of each child (at times reading questions to the child and recording their answers); all 117 questionnaires distributed were returned. In Phu Giao, parents completed the questionnaires; all 81 questionnaires distributed were returned.

Dental examination

Each child received a mirror and sickle probe examination (by TQN) in the classroom, using daylight and a headlight, with the child lying down on a table; TQN stood behind the child's head and viewed their teeth with both direct and mirror vision. Restorations and missing teeth were charted; caries was diagnosed as visible cavitation or discolouration showing through enamel.⁹ A dmft score was calculated for each child. The examination time was recorded (morning: 8:15-10:30am; afternoon: 2:00-3:30pm). Teeth were not cleaned, dried or radiographed due to lack of facilities. A plaque index was recorded by scraping labial surfaces of both maxillary primary central incisors (index teeth) with a sickle probe and assigning scores for plaque located in the gingival one-third (1), gingival plus middle one-thirds (2), or gingival plus middle plus incisal one-thirds (3).¹⁰ The higher of the two plaque scores was designated the child's plaque score. Teachers or parents were advised of the caries status of each child and given advice concerning referral to a dentist in the village.

Statistical analysis

Data were entered into Excel spreadsheets (Microsoft Corp., Seattle, Washington, USA) and distributions were examined using descriptive statistics.

Results

Distribution by age and gender

The study sample of 198, 3-5 yr-olds contained 117 children from Tan Hiep and 81 children from Phu Giao; 96% were aged 4-5 years (Table 1). Similar proportions of females and males were examined in each kindergarten. In total, there were 92 (46%) females and 106 (54%) males.

Completion of questionnaires

In Tan Hiep, teachers completed the questionnaires, addressing children's oral hygiene habits, sweet drinks and sweet foods consumption, drinking water sources, and milk consumption; in Phu Giao parents answered the questions. Information was incomplete for oral hygiene aids (25 children); consumption information was incomplete for: sweet drinks: frequency (2), timing (11); sweet foods: frequency (5), timing (9); milk: intake (4), sweetness (5), type (13), brand (8), frequency (8), timing (24), bedtime intake (12); water source (2).

Dental caries experience

The distribution of dmft scores by gender was similar for both kindergartens, therefore data were collapsed (Table 2). The overall mean dmft \pm SD was 9.8 ± 5.3 ; the mean dmft was higher in Tan Hiep than Phu Giao (10.5 ± 4.9 vs 8.8 ± 5.8). In total, 32 children had missing teeth ($m=68$) and 6 had fillings ($f=7$). Only 6% of children were caries-free; the greatest proportion of children (41%) had a dmft of 10-16. Similar proportions of children in each kindergarten were seen in each dmft range (dmft 1-5: 16% vs 18%; dmft 6-9: 24% vs 27%; dmft 10-16: 48% vs 32%; dmft 17-20: 10% vs 12%). Intra-oral odontogenic infections (not tabulated) were seen in 29 children (swelling: 15; sinus: 13; swelling and sinus: 1).

Children were distributed similarly by age and caries experience for both genders in each kindergarten, therefore data were collapsed (Table 3). In total, one 3 yr-old, seven 4 yr-olds and four 5 yr-olds were caries-free; caries affected 94% of dentitions (mean dmft: 10.4 ± 4.9). Maxillary incisors and/or cuspids (hereafter termed anterior caries pattern) were carious in 85% (mean dmft: 11.1 ± 4.5); proportionally this pattern increased with age (3 yr-olds: 71%; 4 yr-olds: 83%; 5 yr-olds: 90%). Maxillary and/or mandibular molars (hereafter termed posterior caries pattern) were carious in 89% of dentitions (mean dmft: 10.8 ± 4.7); this pattern was similar for all age groups (range: 86-89%). In total, 81% of dentitions had caries affecting both anterior and posterior teeth (mean dmft: 11.6 ± 4.1); this caries pattern increased with age (3 yr-olds: 71%; 4 yr-olds: 80%; 5 yr-olds: 85%). Overall, the mean dmft increased with age (3 yr-olds: 8.2 ± 5.2 ; 4 yr-olds: 10.2 ± 5.1 ; 5 yr-olds: 11 ± 4.5 ; Figure 1).

The distribution of children by age and carious surfaces was similar for both genders in each kindergarten; therefore data were collapsed (Table 4). The carious surfaces on maxillary anterior teeth were predominantly labial (73%) and proximal (70%). The proportion of dentitions where these surfaces were caries-free decreased with age (labial: 3 yr-olds: 71%, 4 yr-olds: 27%, 5 yr-olds: 22%; proximal: 3 yr-olds: 43%, 4 yr-olds: 32%, 5 yr-olds: 26%).

Maxillary molars were more likely to have carious buccal surfaces than mandibular molars (62% vs 39%; Table

4). Proportionally, caries-free molar lingual surfaces were similar for both arches (86% vs 83%). Caries on proximal surfaces was similar for maxillary and mandibular molars (31% vs 38%), increasing with age (maxillary: 3 yr-olds: 14%; 4 yr-olds: 22%; 5 yr-olds: 45%; mandibular: 3 yr-olds: 0; 4 yr-olds: 8%; 5 yr-olds: 55%). Occlusal surfaces were the most frequently carious surfaces in maxillary and mandibular molars (60% vs 74%), increasing with age (maxillary: 3 yr-olds: 43%; 4 yr-olds: 55%; 5 yr-olds: 70%; mandibular: 3 yr-olds: 72%; 4 yr-olds: 73%; 5 yr-olds: 76%). Overall, the mean dmfs increased with age (3 yr-olds: 9.6 ± 10.2 ; 4 yr-olds: 15.2 ± 11.8 ; 5 yr-olds: 18.3 ± 14.2).

Oral hygiene practices

All children were reported to have their teeth cleaned daily (1/day: 9%; 2/day: 51%; ≥ 3 /day: 40%; Table 5). Most frequently, teeth were cleaned before breakfast plus before bedtime (49%), or before plus after breakfast plus before bed (28%). Cleaning before plus after breakfast plus before bed was more frequent in Tan Hiep than Phu Giao (46% vs 2%), and cleaning before breakfast plus before bedtime was more frequent in Phu Giao than Tan Hiep (68% vs 37%). In both kindergartens, children were instructed (unsupervised) to brush after lunch using individual tooth brushes kept at school and a communal tube of fluoride toothpaste (P/S™ Unilever Co. Ltd., Vietnam). For most children, tooth brush and/or toothpaste was the sole oral hygiene aid reported (71%). Tooth cleaning was performed by 75% of children by themselves, by parents for 23%, and by both parents and children for 2% (not tabulated).

Plaque on maxillary primary central incisors

Plaque distribution on labial surfaces of maxillary primary central incisors (index teeth) was similar for both genders and both kindergartens, therefore data were collapsed (Table 6). Only 6% of children were plaque-free on these surfaces; plaque was present on gingival one-third (26% of children), gingival plus middle one-thirds (24%), gingival plus middle plus incisal one-thirds (4%). Carious or missing labial surfaces of index teeth precluded plaque scoring for 35% and 6% of children respectively; plaque was present on the gingival one-third plus middle one-thirds in 85% (99/117) of those who had these surfaces present.

The distribution of plaque in relation to examination time (morning or afternoon) showed little difference. Morning examinations (143 children) were conducted following variable home tooth brushing; afternoon examinations (55) were conducted after children had eaten, self-brushed their teeth (unsupervised) and taken a nap. Self-brushing was ineffective in removing plaque from index teeth in almost all children; plaque-free incisors were seen in only 6% of those examined in the morning and in 4% of those examined in the afternoon. Tooth brushing time had no effect on plaque; similar plaque distributions were seen on index teeth regardless of variable home brushing (morning) or confirmed afternoon brushing (at school). The median plaque scores for those examined in the morning and afternoon were both 1 (not tabulated).

Consumption of sweet drinks, sweet foods and water

Consumption patterns for sweet drinks, sweet foods and water were similar for both genders and both kindergartens, therefore data were collapsed (Table 7). Overall, 13% of children reported not drinking sweet drinks, but most (43%) consumed sweet drinks 2/day and frequently between meals (79%). In total, 5% reported not consuming sweet foods, but most (52%) consumed sweet foods 2/day and frequently between meals (85%). All children drank water, usually sourced from a tap (58%) or well (17%), or purchased as bottled water (17%).

Tooth brushing, intake of sweet drinks and sweet foods, and caries experience

The reported distributions for tooth brushing, intakes of sweet drinks and sweet foods, and caries experience are shown (Table 8). Mean dmft was unrelated to frequency of tooth brushing (1/day: 10.8 ± 4.6 ; 2/day: 9.7 ± 5.7 ; 3/day: 9.7 ± 5.1). Mean dmft was lowest for children who brushed before breakfast plus before bed (8.9 ± 5.8), and highest for those who brushed before breakfast with/without brushing after breakfast (11.9 ± 5.3). The mean dmft was similar for children who cleaned with a tooth brush plus toothpaste plus another aid (9.5 ± 5.6) and for those who cleaned with a tooth brush plus/or toothpaste only (9.8 ± 5.4). The mean dmft increased with increasing frequency of consumption of sweet drinks and/or sweet foods (none/day: 7.0 ± 6.4 ; 1-2/day: 8.9 ± 5.2 ; 3-4/day:

10.2 ± 5.3; ≥5/day: 11.2 ± 5.5). The mean dmft for consumption of sweet items between meals and with meals was similar (sweet drinks: 10.0 ± 5.2 vs 9.9 ± 5.6; sweet foods: 9.9 ± 5.4 vs 9.5 ± 4.9).

The distributions for tooth brushing, sweet intakes, and caries patterns are shown (Table 8). Increased brushing frequency was related to a greater proportion of caries-free dentitions (1/day: 0%; 2/day: 5%; ≥3/day: 9%). Brushing frequency was unrelated to specific caries patterns (anterior or posterior caries only: range 6-17%; anterior plus posterior caries: range 78-94%). Tooth brush timing associated with the most caries-free dentitions was before breakfast plus before bed (10%), as well as fewest dentitions with anterior plus posterior caries (72%). Among children who cleaned before bed with/without after breakfast, there were no caries-free dentitions and the proportion of children with anterior plus posterior caries was highest (94%). Children who cleaned with a tooth brush and/or toothpaste only had the greatest proportion of dentitions with anterior plus posterior caries (81%). As sweet drink and/or sweet food consumption increased, caries-free dentitions decreased (none/day: 17%; 1-2/day: 8%; 3-4/day: 6%; ≥5/day: 0), and anterior plus posterior caries increased (none/day: 50%; 1-2/day: 77%; 3-4/day: 83%; ≥5/day: 92%). The proportion of children with caries on both anterior and posterior teeth was higher when sweet items were consumed between, rather than with, meals (sweet drinks: 85% vs 79%; sweet foods: 83% vs 78%).

Consumption of milk and caries experience

Consumption patterns for milk were similar for both genders and both kindergartens, therefore data were collapsed (Table 9). All but one child reported drinking milk, typically ≥2/day (85%). Milk which 'tasted sweet' was used as a proxy for sweet milk consumption: 98% of children reported drinking sweet-tasting milk. Milk was consumed frequently between meals (83%) and before bedtime (81%). Most children drank milk from a carton (70%); milk prepared from milk powder or condensed milk was also consumed. Two popular milk brands (Vinamilk™ and Dutch Lady™) were consumed by 80% of children.

The reported distributions of milk

consumption and caries experience are shown (Table 9). The mean dmft was slightly higher when milk was consumed between, rather than with, meals (10.0 ± 5.4 vs 9.3 ± 5.8). High caries experience was associated with regular consumption of the milk brands shown (range: 8.7 ± 6.1 – 12.8 ± 4.6). Overall, the mean dmft increased with frequency of milk intake (1/day: 8.8 ± 6.2; 2/day: 9.8 ± 5.2; ≥ 3/day: 10.7 ± 5.3, Figure 2). As frequency of milk consumption increased, the proportion of caries-free dentitions decreased (1/day: 19%; 2/day: 4%; ≥ 3/day 3%; Table 9). The proportion of dentitions with anterior plus posterior caries was higher when consumption was between, rather than with, meals (83% vs 72%), but did not appear related to milk type or brand.

The total intakes of sweet drinks, sweet foods and sweet milk and caries experience are shown (Figure 3). Caries experience increased with increasing total intakes (1-2/day: 7.6 ± 4.7; 3-4/day: 9.4 ± 5.3; 5-6/day: 10.0 ± 5.4; ≥7/day: 10.8 ± 5.3). Many children (89/198, 45%) had a total sweets intake of 5-6/day (not tabulated). The proportion of children with anterior plus posterior caries increased with increasing frequency of total sweet intakes (1-2/day: 56%; 3-4/day: 84%; 5-6/day: 82%; ≥7/day: 89%; Figure 4).

Discussion

This study conducted in 2011 in two rural villages in Vietnam confirmed the high caries experience found in 2010,¹ when preschool children from the same kindergartens were studied. In 2011, the questionnaires addressing child habits and dietary intakes were completed by different individuals in each kindergarten (by teachers in Tan Hiep and by parents in Phu Giao), and the information provided could not be verified. Therefore, differences observed in intakes and oral hygiene behaviours may reflect reporting differences rather than real differences. Further, large standard deviations noted for several mean values may in part reflect small sample sizes.

The present study observed an increase in caries experience over that observed in children from the same kindergartens in 2010.¹ Although similar proportions of children were affected by caries (94% vs 93%), the mean dmft was higher in 2011 than in 2010 (9.8 ± 5.3 vs 6.6 ± 4.5) and the sample had more

widespread disease: the modal dmft range was 10-16 (for 41%) in 2011 and 2-9 (63%) in 2010. This could reflect the older sample in 2011, where the mean age was 4.3 ± 0.5 yrs compared with 2.7 ± 0.7 yrs in 2010, noting that in a high caries risk population without access to dental care caries experience is likely to increase with age.

Concerning dental caries patterns, children in 2011 had more dentitions with caries on both anterior and posterior teeth than seen in 2010 (81% vs 59%), and fewer dentitions with caries limited to incisors and/or canines only (5% vs 12%) or molars only (7% vs 23%).¹ This suggests that initial caries patterns associated with specific aetiological factors disappeared as the children grew older and more teeth in each dentition became carious. In the 2011 sample, as age increased, the proportion of dentitions with anterior plus posterior caries increased, and incisor and/or canine caries also increased, while molar caries stayed relatively constant. This increased caries experience with age associated with the development of more anterior carious lesions, mostly labial and proximal, followed the typical pattern ascribed to ECC.^{11,12}

The higher caries experience seen in 2011 may also reflect inter-examiner variability and the method of dental examination. In 2010, the child was seated on a chair with their head tilted back while the examiner sat in front to conduct the examination. In 2011, the child lay on a table while the examiner viewed the teeth from behind and above. The latter method was closer to operatory conditions and could have enhanced detection of carious lesions.

The caries experience of these rural children in Vietnam was higher than reported recently in a similarly-aged group in a non-fluoridated community in another developing country, Nigeria, where the most common dmft range was 1-6 (40%) and 29% of children were caries-free.¹³ In comparison, in our sample of children in rural Vietnam, the most common dmft range was 10-16 (41%), 81% had caries on both anterior and posterior teeth, and only 6% were caries-free. Based on the definition of Drury et al.⁹ of severe ECC as a dmfs score of ≥4 (3 years), ≥5 (4 years), ≥6 (5 years), at least 81% of the children had severe ECC. This high caries experience suggests major aetiological factors are involved in these children.

The oral hygiene of the children did not appear to be effective. Despite 91% reporting tooth brushing ≥ 2 /day, plaque on the gingival one-third or gingival plus middle one-thirds of maxillary primary central incisors remained in 85% of those with index surfaces to score. The median plaque scores did not differ between children examined in the morning (following variable home oral hygiene) and those examined in the afternoon (school-based brushing). Oral hygiene may also have been ineffective because most children (75%) were unassisted in home tooth brushing and school-based brushing was unsupervised. Parental tooth brushing was reported for 23% of children; however, given the levels of plaque accumulation observed, this assisted cleaning was also ineffective. A positive correlation between visible plaque on anterior primary teeth and caries risk has been reported,¹⁴ but extensive plaque and high caries experience of the children precluded any correlation in the present study.

Although the proportion of caries-free dentitions decreased with increasing tooth brushing frequency, no relationship was seen between brushing frequency and mean dmft. Further, children reporting brushing before plus after breakfast plus before bedtime did not have the lowest mean dmft and the mean dmft differed little from other brushing times. Tooth brushing time associated with least caries was before breakfast plus before bedtime; these children had the lowest mean dmft (8.9), most caries-free dentitions (10%), and least anterior plus posterior caries (72%).

In 2010, high intakes of sweet drinks and sweet foods were reported, associated with high caries experience.¹ However, some children reporting none or low intake of sweet drinks and sweet foods had unexpectedly high caries experience and it was suggested that other cariogenic factors could be contributing, such as sweet milk.¹ In 2011, we noted a similarly high sweet intake, and also a high sweet milk intake (98%), consumed by 85% of children ≥ 2 /day. Local vendors provided anecdotal evidence of the popularity of sweet milk in this community, particularly in carton form. They believed sweet milk in a carton provides a quick and satisfying snack, without the need to mix powder or dilute condensed milk. This notion is supported by the fact that milk consumption was

reported by 83% of children between meals, and 81% before bedtime. The sugar content of milk is fully disclosed by manufacturers; the terms “sweetened” and “sugar” are clearly visible on the cartons of popular brands (eg, Dutch Lady™ and Vinamilk™). This suggests a market preference for sweet milk and perhaps a lack of awareness of the adverse effects of excessive sweet consumption on dental health. Socially in these communities, in contrast to sweet drinks and sweet foods, sweet milk is perceived as nutritious and necessary for the growing child. Therefore, any modifications that make the child more inclined to consume the milk, such as addition of sugar, are welcomed by parents. Consequently, preventive messages advising reduced consumption of sweet milk may be difficult for the community to adopt.

Sweet milk consumption appeared to contribute to caries experience of these children, as mean dmft increased with increasing intake frequency. With sweet milk providing an additional cariogenic exposure, 45% of children had total sweet intakes (sweet drinks plus sweet foods plus sweet milk) as high as 5-6 times/day, and mean dmft increased with increasing frequency of total sweet intakes. As the frequency of total sweets intake increased, a greater proportion of children experienced caries on both anterior and posterior teeth, representing a severe pattern of ECC.^{11,12}

The children studied in 2011 had received little dental treatment; only 7 restorations were observed in 6 children and 29 children had odontogenic infections. Due to overlapping age groups, some children examined in 2011 had also been examined in 2010 and would have received advice at that time regarding the need for treatment. Clearly, many families had not sought treatment thereafter for their children, possibly due to failure to follow the advice, or unavailability of accessible dental care.

Conclusion

Preschoolers in these rural villages in Vietnam have very high caries experience including cases of odontogenic infections. The need for dental services and oral health promotion, which should address dietary intakes including sweet milk, continues to be very urgent.

Acknowledgements

The authors acknowledge with gratitude the financial support of GC Corporation; the Rotary Australia Vietnam Dental Health Project 2011 team for providing the opportunity for this study; the local dental staff and hospital staff of the Tan Hiep District Hospital and Phu Giao District Health Centre for their care and hospitality; and the staff of the National Hospital of Odontostomatology, Ho Chi Minh City for their support.

For Further Information

For further information on the Rotary Australia Vietnam Dental Health Project, readers are encouraged to contact Dr James Robertson, on: jamie@robident.com.au

The findings of this research were presented at the IADR ANZ Division meeting in Melbourne, September 2011 (Poster No.C-19).

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Table 1. Distribution of 198 children aged 3-5 yrs (117 in Tan Hiep and 81 in Phu Giao) by age and gender

Age (years)	Distribution of children				Total children (N = 198) (%)
	Tan Hiep (N = 117)		Phu Giao (N = 81)		
	Female (n = 55)	Male (n = 62)	Female (n = 37)	Male (n = 44)	
3	0	0	2	5	7 (4)
4	25	33	27	34	119 (60)
5	30	29	8	5	72 (36)
Total (%)	55 (47)	62 (53)	37(46)	44 (54)	198 (100)

Table 2. Caries experience of 198 children aged 3-5 yrs in Tan Hiep and Phu Giao

Caries experience (dmft range) ^(a)	Distribution of children		Total children (N = 198) n (%)
	Tan Hiep (N = 117) (%)	Phu Giao (N = 81) n (%)	
0	3 (3)	8 (10)	11 (6)
1-5	18 (16)	15 (18)	33 (17)
6-9	28 (24)	22 (27)	50 (25)
10-16	56 (48)	26 (32)	82 (41)
17-20	12 (10)	10 (12)	22 (11)
Mean dmft (±SD)	10.5 (4.9)	8.8 (5.8)	9.8 (5.3)

(a) Included 7 filled teeth and 68 missing teeth

Table 3. Distribution of 198 children aged 3-5 yrs in Tan Hiep and Phu Giao by age and caries experience of primary tooth groups

Caries experience (primary teeth)	Distribution of children			Total children (N= 198) n (%)	Mean dmft (± SD)
	Three year-olds (N = 7) n (%)	Four year-olds (N = 119) n (%)	Five year-olds (N = 72) n (%)		
Caries-free	1 (14)	7 (6)	4 (6)	12 (6)	0
≥1 carious surface/s	6 (86)	112 (94)	68 (94)	186 (94)	10.4 (4.9)
Caries on Mx incisors +/- or cuspids	5 (71)	99 (83)	65 (90)	169 (85)	11.1 (4.5)
Caries on Mx incisors +/- or cuspids only ^(a)	0	6 (5)	4 (6)	10 (5)	2.9 (1.4)
Caries on Mx +/- or Md molars	6 (86)	106 (89)	64 (89)	176 (89)	10.8 (4.7)
Caries on Mx +/- or Md molars only ^(b)	1 (14)	10 (8)	3 (4)	14 (7)	2.6 (0.9)
Caries on anterior + posterior teeth	5 (71)	95 (80)	61 (85)	161 (81)	11.6 (4.1)
Mean dmft (± SD) of carious dentitions	8.2 (5.2)	10.2 (5.1)	11 (4.5)	10 (4.9)	

(a) Posterior teeth caries-free (b) Anterior teeth caries-free

Table 4. Caries experience of tooth surfaces of 198 children 3-5 yrs in Tan Hiep and Phu Giao

Primary teeth and tooth surfaces		Caries experience (dmfs range) ^(a)	Distribution of children			Total children (N= 198) n (%)
			Three year-olds (N = 7) n (%)	Four year-olds (N = 119) n (%)	Five year-olds (N = 72) n (%)	
Maxillary Anterior Teeth ^(b)	Labial	0	5 (71)	32 (27)	16 (22)	53 (27)
		1-6	2 (29)	87 (73)	56 (77)	145 (73)
	Lingual	0	6 (86)	76 (64)	53 (74)	135 (68)
		1-6	1(14)	43 (36)	19 (27)	63 (32)
	Proximal	0	3 (43)	38 (32)	19 (26)	60 (30)
		1-12	4 (58)	81 (68)	53 (73)	138 (70)
Maxillary Molars	Buccal	0	3 (43)	56 (47)	36 (50)	95 (48)
		1-4	4 (57)	63 (53)	36 (50)	103 (62)
	Lingual	0	7 (100)	110 (92)	54 (75)	171 (86)
		1-4	0	9 (8)	18(25)	27(14)
	Proximal	0	6 (86)	92 (77)	40 (56)	138 (70)
		1-8	1 (14)	27 (22)	32 (45)	60 (31)
	Occlusal	0	4 (57)	54 (45)	21 (29)	79 (40)
		1-4	3 (43)	65 (55)	51 (70)	119 (60)
Mandibular Anterior Teeth ^(b)	Labial	0	5 (71)	71 (60)	45 (63)	121 (61)
		1-6	2 (29)	48 (41)	27 (38)	77 (39)
	Proximal	0	7 (100)	88 (74)	51 (71)	146 (74)
		1-12	0	31 (26)	21 (29)	52 (27)
Mandibular Molars	Buccal	0	4 (57)	78 (66)	40 (56)	122 (62)
		1-4	3 (43)	41 (34)	32 (45)	76 (39)
	Lingual	0	7 (100)	109 (92)	49 (68)	165 (83)
		1-4	0	10 (8)	23 (32)	33 (17)
	Proximal	0	7 (100)	86 (72)	32 (44)	125 (63)
		1-8	0	33 (8)	40 (55)	73 (38)
	Occlusal	0	2 (29)	32 (27)	17 (24)	51 (26)
		1-4	5 (72)	87 (73)	55 (76)	147 (74)
Mean dmfs (±SD)			9.6 (10.2)	15.2 (11.8)	18.3 (14.2)	16.1 (12.8)

(a) dmfs based on visual examination only (radiographs not taken)

(b) Primary incisors and canines

Table 5. Reported oral hygiene practices of 198 children aged 3-5 yrs in Tan Hiep and Phu Giao

Oral hygiene practices	Distribution of children		Total children (N = 198) n (%)
	Tan Hiep (N = 117) (%)	Phu Giao (N = 81) n (%)	
Tooth brushing:			
1 /day	1 (1)	16 (20)	17 (9)
2 /day	49 (42)	52 (64)	101 (51)
≥3 /day	67 (57)	13 (16)	80 (40)
Time teeth brushed:			
Before+after bkfst+ before bedtime	54 (46)	2 (2)	56 (28)
Before bkfst+ before bedtime	43 (37)	55 (68)	98 (49)
Before ± after bkfst	16 (14)	12 (15)	28 (14)
Before bedtime ± after bkfst	4 (3)	12 (15)	16 (8)
Oral hygiene aids used:			
Tbrush + tpaste + other ^(a)	8 (7)	21 (26)	29 (15)
Tbrush +/- or tpaste only	83 (71)	57 (71)	140 (71)
Other aids ± tbrush	1 (1)	3 (4)	4 (2)
Missing data	25 (21)	0	25 (13)

(a) Other oral hygiene aids: salty water +/- water (27 children); mouthwash (4); toothpicks ± water (2)

Table 6. Location of plaque on labial surfaces of maxillary primary central incisors of 198 children aged 3-5 yrs in Tan Hiep and Phu Giao

Location of plaque on labial surfaces of maxillary primary central incisors (index teeth)	Distribution of children		
	Morning exam ^(a) (N = 143) n (% of total)	Afternoon exam ^(b) (N=55) n (% of total)	Total children (N = 198) n (%)
No plaque	9 (6)	2 (4)	11 (6)
On gingival one-third	39 (27)	13 (24)	52 (26)
On gingival + middle one-thirds	35 (24)	12 (22)	47 (24)
On gingival + middle + incisal one-thirds	5 (3)	2 (4)	7 (4)
Labial surfaces carious ^(c)	44 (31)	25 (45)	69 (35)
Mx central incisors missing ^(d)	10 (7)	2 (4)	12 (6)

(a) Variable tooth brushing at home prior to clinical examination (morning) (b) Tooth brushing conducted at school prior to clinical examination (afternoon)

(c) Caries on labial surface precluded plaque scoring (d) Primary maxillary central incisors absent, precluding scoring

Table 7. Reported consumptions of sweet items and water by 198 children aged 3-5 yrs in Tan Hiep and Phu Giao

Consumption pattern (no. responses)	Total children (N=198) n (valid %)
Intake of sweet drinks (n=196):	
None	26 (13)
1 /day	66 (34)
2 /day	84 (43)
≥ 3 /day	20 (10)
Time of sweet drinks (n=163):	
Between meals	129 (79)
With meals	34 (21)
Intake of sweet foods (n=193):	
None	9 (5)
1 /day	61 (32)
2 /day	101 (52)
≥ 3 /day	22 (11)
Time of sweet foods (n=180):	
Between meals	153 (85)
With meals	27 (15)
Drink water (n=198):	198 (100)
Water source (n=196):	
Tap	113 (58)
Well	34 (17)
Bottled	34 (17)
Tap + bottled	15 (8)

Table 8. Distribution of 198 children aged 3-5 yrs in Tan Hiep and Phu Giao by oral hygiene, sweet intakes, caries experience caries pattern

Distribution (no. responses)	Distribution of children				
	Total children n (valid %)	Mean dmft (\pm SD)	Caries-free (N = 12) n (% of total)	Ant or post caries only (N = 25) n (% of total)	Ant + post caries (N = 161) n (% of total)
Tooth brushing (n = 198):					
1 /day	17 (9)	10.8 (4.6)	0	1 (6)	16 (94)
2 /day	101 (51)	9.7 (5.7)	5 (5)	17 (17)	79 (78)
≥ 3 /day	80 (40)	9.7 (5.1)	7 (9)	7 (9)	66 (83)
Time teeth brushed (n = 198):					
Before+after bkfast+ before bed	56 (28)	10.0 (4.4)	1(2)	5 (9)	50 (89)
Before bkfast+ before bed	98 (49)	8.9 (5.8)	10 (10)	17 (17)	71 (72)
Before\pm after bkfast	28 (14)	11.9 (5.3)	1 (4)	2 (7)	25 (89)
Before bed\pm after bkfast	16 (8)	10.3 (4.4)	0	1 (6)	15 (94)
Oral hygiene aids (n=173):					
Tbrush + tpaste + other	29 (17)	9.5 (5.6)	1 (3)	7 (24)	21 (72)
Tbrush +/-or tpaste only	140 (81)	9.8 (5.4)	10 (7)	16 (11)	114 (81)
Other aids \pm tbrush	4 (2)	7.0 (3.7)	0	1 (25)	3 (75)
Intake of sweet drinks +/-sweet foods (n = 196):					
None	3 (50)	7.0 (6.4)	1 (17)	2 (33)	2 (33)
1-2 /day	48 (77)	8.9 (5.2)	5 (8)	9 (15)	9 (15)
3-4 /day	86 (83)	10.2 (5.3)	6 (6)	12 (12)	12 (12)
≥ 5 /day	22 (92)	11.2 (5.5)	0	2 (8)	2 (8)
Time of sweet drinks (n = 163):					
Between meals	129 (78)	10.0 (5.2)	7 (5)	13 (10)	109 (85)
With meals	34 (21)	9.9 (5.6)	2 (6)	5 (15)	27 (79)
Time of sweet foods (n = 181):					
Between meals	153 (85)	9.9 (5.4)	10 (7)	16 (10)	127 (83)
With meals	27 (15)	9.5 (4.9)	0	6 (22)	21 (78)

Table 9. Distribution of 198 children aged 3-5 yrs in Tan Hiep and Phu Giao by milk consumption and caries experience

Consumption pattern (no. responses)	Distribution of children				
	Total children (N=198) n (valid %)	Mean dmft (\pm SD)	Caries-free (N = 12) n (% of total)	Ant or post caries only (N = 25) n (% of total)	Ant + post caries (N = 161) n (% of total)
Milk intake (n=190):					
None	1 (1)	13.0	0	0	1 (100)
1 /day	27 (14)	8.8 (6.2)	5 (19)	3 (11)	19 (70)
2 /day	122 (64)	9.8 (5.2)	5 (4)	15 (12)	102 (84)
≥ 3 /day	40 (21)	10.7 (5.3)	1 (3)	6 (15)	33 (83)
Milk tastes sweet (n=192):	188 (98)	9.8 (5.4)	12 (6)	23 (12)	153 (81)
Milk time (n=173):					
Between meals	144 (83)	10.0 (5.4)	8 (6)	17 (12)	119 (83)
With meals	29 (17)	9.3 (5.8)	2 (7)	6 (21)	21 (72)
Milk before bed (n=185):	150 (81)	9.7 (5.3)	9 (6)	19 (13)	122 (81)
Milk type (n=183):					
Carton	129 (70)	10.2 (5.4)	7 (5)	15 (12)	107 (83)
Carton + powder	27 (15)	8.8 (5.5)	2 (7)	5 (19)	20 (74)
Powder +/-or condensed	27 (15)	9.1 (4.8)	1 (4)	4 (15)	22 (81)
Milk brand (n=189):					
Dutch Lady TM	61 (32)	9.4 (5.2)	3 (5)	10 (16)	48 (79)
Vinamilk TM	74 (39)	10.3 (5.5)	6 (8)	7 (9)	61 (82)
Dutch Lady TM + Vinamilk TM	17 (9)	9.2 (3.4)	0	0	17 (100)
Abott TM +/-or Enfa TM	10 (5)	8.7 (6.1)	0	3 (30)	7 (70)
Other brand	11 (6)	12.8 (4.6)	0	0	11 (100)
Dutch Lady TM +/-or Vinamilk TM + (Abott TM / Enfa TM / Nestle TM / Other)	16 (8)	9.6 (6.1)	1 (6)	4 (25)	11 (69)

Figure 1. Caries experience vs age of 198 children aged 3-5 yrs in Tan Hiep and Phu Giao

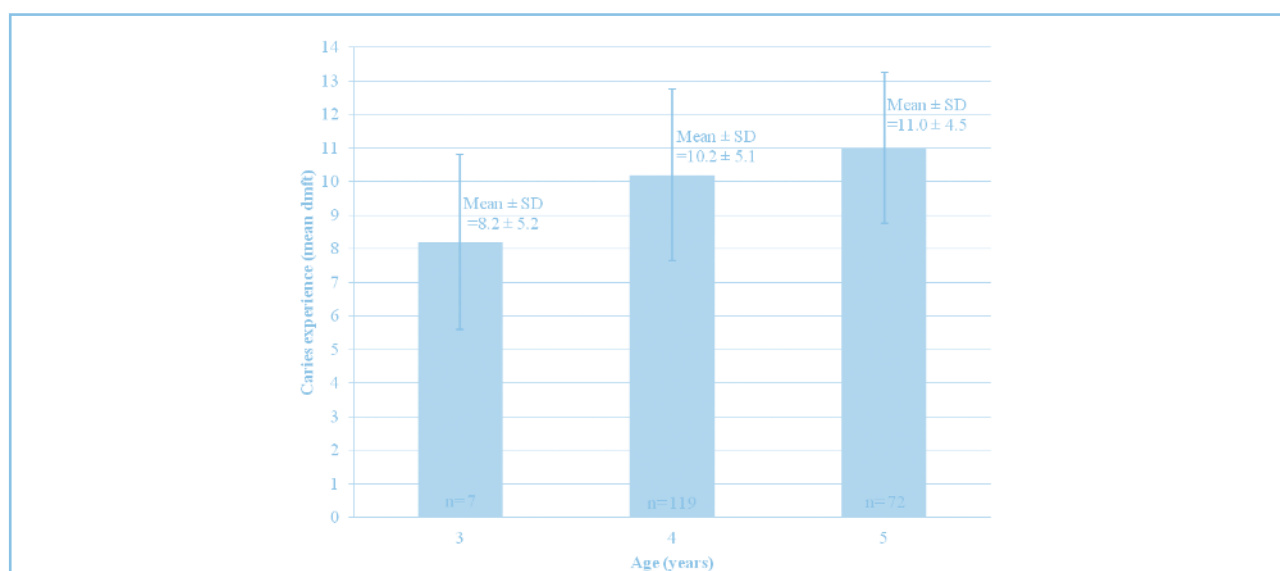


Figure 2. Caries experience vs frequency of milk intake of 198 children aged 3-5 yrs in Tan Hiep and Phu Giao

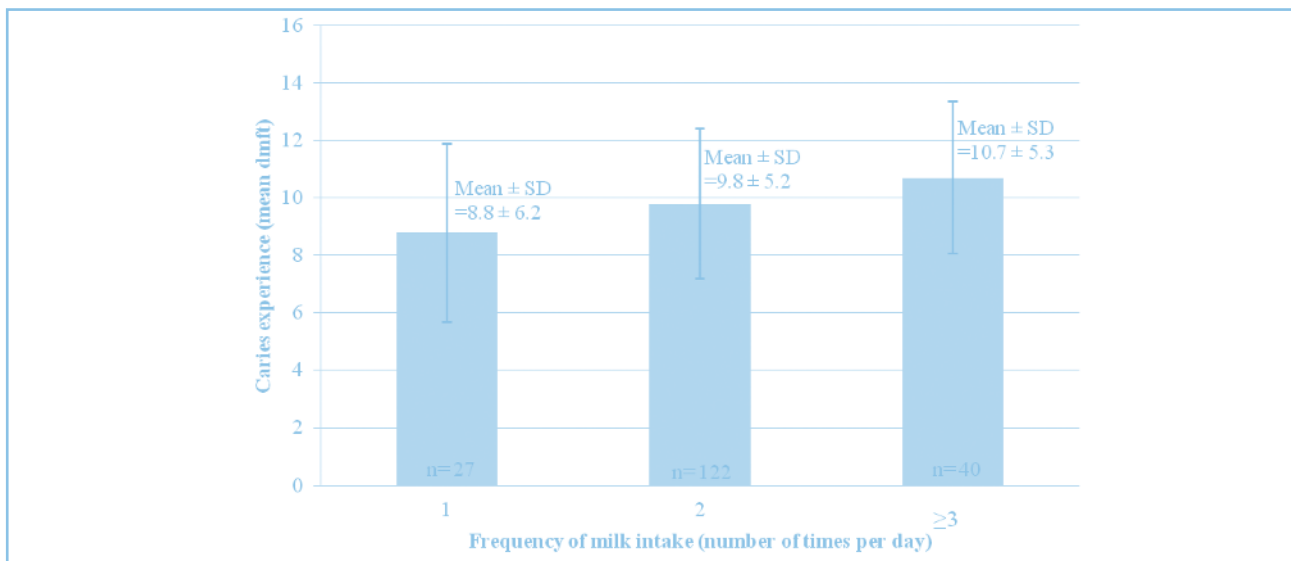


Figure 3. Caries experience vs frequency of total intake of sweet foods, sweet drinks and sweet milk in 198 children aged 3-5 yrs in Tan Hiep and Phu Giao

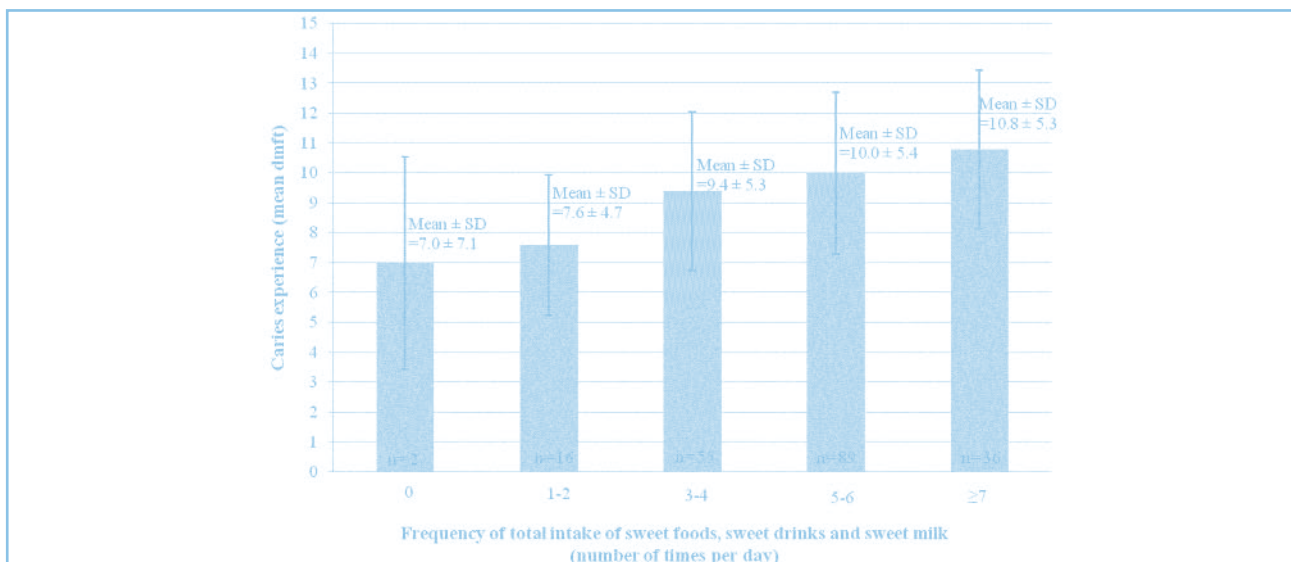
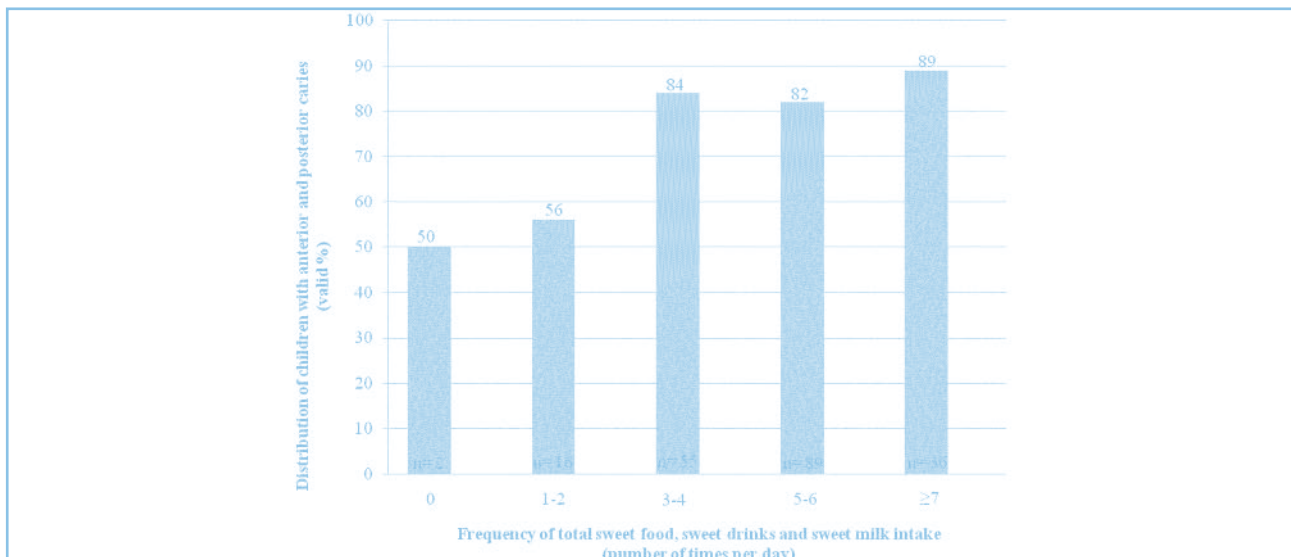


Figure 4. Distribution of children with anterior and posterior caries vs frequency of total intake sweet food, sweet drinks and sweet milk in 198 children aged 3-5 yrs in Tan Hiep and Phu Giao



2012 ANZSPD



Colgate Paediatric Dentistry Post-Graduate Research Award

Once again, through the generous sponsorship provided by Colgate Oral Care, any post-graduate student currently enrolled in a paediatric dentistry masters degree or Ph.D./doctorate program, or any student who has completed any of one of these programs since the end of 2009, is invited to compete for this award.

The winner will receive a single return economy airfare and a cash prize of AU\$500.00 to assist in the payment for registration and accommodation to attend and present the same paper at an appropriate international meeting e.g. the 24th International Association of Paediatric Dentistry Congress. All competitors will receive free registration for the 17th A.N.Z.S.P.D. Federal Convention, 20th-21st July 2012 to be held in Canberra, ACT

Competitors will be required to present a paper at the Canberra Convention on completed work undertaken in their graduate program.

Papers will be judged on:

1. Subject matter
2. Research significance
3. Presentation and delivery of the paper
4. Quality of the audio-visual material in the presentation
5. Abstract

The time allowed for each presentation will be limited to 10 minutes each with 5 minutes for questions, although the time for the actual presentations may be a little longer depending on the number of competitors.

Applicants are requested to submit their application and the abstract of their proposed presentation by **Tuesday, 15th May 2012** to:

Dr A.M. Devlin
Secretary-Manager A.N.Z.S.P.D.
At devlins@iinet.net.au

The cost of travel to Canberra and for accommodation whilst in Canberra will be the responsibility of the individual; however, they may seek subsidy from their local A.N.Z.S.P.D. Branch. All eligible graduate students are encouraged to participate in this prestigious award. Past winners have been Dr Kerrod Hallett, Dr Tim Johnston, Dr Suzanne Brent, Dr Sam Gue, Dr Lochana Ramalingam, Dr Juliette Scott, Dr Fiona Bell and Dr Susan Hseih.

Dr Alistair Devlin
Secretary-Manager, ANZSPD

The ANZSPD Grant

At the ANZSPD Federal Council meeting in Perth in March 2009, it was decided to institute the ANZSPD Grant. The plan is to provide one grant per year to the value of AU\$2,000.00 with all full members of ANZSPD eligible to be considered.

The Grant is available for:

- an oral health initiative in Australia or New Zealand which may be an educational resource or a broad community initiative
- a community research project directly related to child oral health
- support for an oral health project in Asia, Oceania or the Pacific which might be for materials, instruments, books for a school, etc.

Applications are now being called for the inaugural Grant. Applications should be submitted electronically to the Federal Secretary-Manager by 31st July 2012 at devlins@iinet.net.au

Federal Council will then adjudicate. The successful recipient will be required to provide a report to the Federal Council by the end of 2013. The Federal Council may choose not to award a Grant in the event of there being no suitable applications.

The International Association of Paediatric Dentistry

Presents

COLGATE Bright Smiles, Bright Futures Award

Award

Goals & Criteria

Community oral health education programs involving dental professionals, primary school educators and parents, working together, to help children develop and maintain sound oral health habits is a goal of the International Association of Paediatric Dentistry (IAPD).

The IAPD is pleased to announce an award program to recognize community oral health education programs designed to improve the oral health habits of children. The purpose of this award is to stimulate the development of innovative programs worldwide and to facilitate information sharing and transfer. This program is generously supported by the Colgate-Palmolive Company.

IAPD awards prizes at the biennial IAPD Congress. The Bright Smiles, Bright Futures Award will be given for the best community oral health education program submitted. All programs that the Award Committee considers fulfil the eligibility conditions will receive an IAPD Certificate of Recognition, and be given the opportunity to present at the next Congress. The best program selected by the judges will receive an award of \$2000 USD from June 12-15 in Seoul, Korea, where this award will be presented.

Eligibility

- Any individual or organisation responsible for creating or implementing a preventive oral health community program serving children may apply.
- Programs may be in any academic, clinical or community-based setting, such as a school, health or community centre serving children. Attention to daily motivation activities is encouraged.
- Existing programs and newly created ones that have objectives and measurable goals will be considered.
- Programs will be judged on impact, educational materials and presentation.

IMPACT: How well the children are being motivated and/or educated.

MATERIALS: How innovative the materials are, how clearly they tell a story, and how well they enable educators and parents to work together.

PRESENTATION: How well the concepts are displayed and can be transferred, based on the presentation of the program design and details.

• To be eligible, programs should be underway by March of 2012 in order to demonstrate results in 2013.

Application

- Applications should be received by January 1, 2013 for consideration by the Judges. Applicants unable to complete their submissions by that date should contact the IAPD Secretariat for an extension.
- A 100 word abstract and a three page description of the program should be included with the completed application. Supporting educational materials used in the program may be requested by the judges. (Entry materials cannot be returned.)
- Judging will be conducted by the IAPD Award Committee, made up of representatives of the International Association of Paediatric Dentistry, and a representative of Colgate-Palmolive.

FOR ENTRY APPLICATIONS PLEASE CONTACT SYLVIE DUTILLOY WITH IAPD.

The International Association of Paediatric Dentistry, established in 1969, now represents over 10,000 dentists worldwide. IAPD's goal is to contribute to the progress and promotion of dental health for children and to encourage research and programs in this field. IAPD meetings and the International Journal of Paediatric Dentistry act as forums for the exchange and transfer of international information concerning paediatric dentistry.

All dentally qualified applicants for this award are encouraged to become members of IAPD. Forward completed applications to:

Sylvie Dutilloy

IAPD

c/o FDI World Dental Federation

iapd@fdiworldental.org





ANZSPD Sponsored Pre Congress “Hands On” Course Athens IAPD June 2011

Richard P Widmer and Dr Sotiria Gizani

Dear Dr Mekertichian Federal President
ANZSPD,

Please find enclosed the report of the Pre-Congress “Hands On” course held on Wednesday the 15th of June, in Athens. This course was part of the IAPD Congress Athens, Greece and was, as you know sponsored by the ANZSPD (Fed).

Background

The idea of having a technical course as a pre-Congress course has been with the IAPD Board for sometime. The IAPD, by its very nature, is not involved with setting “standards of care” for individual countries/academies. It is about providing a clinical forum, which includes not only didactic material but technical instruction as well. Thus the world audience, interested in paediatric dentistry, can find all manner of stimulation at an IAPD meeting. It was, in this light the LOC of the Athens Conference offered the “hands-on” Course as a pre-Congress course.

Planning

The Chair of the LOC, Prof Lisa Papagiannoulis asked both myself and Dr Sotiria Gizani

(Snr Lecturer in the Fac of Dentistry at the Univ. of Athens Dental School) to plan the hands on course for the Congress. In August of 2010 I went to Athens to meet both Prof Papagiannoulis and Dr Gizani and review the facilities available for the Course. This was a most productive two days and we all felt it was instrumental in the later success of the course.

Once Dr Gizani and I had met in Athens we drew up a plan for the day and Dr Gizani then prepared a very detailed budget. We then developed the details of the Course. The proposed lecturers for the morning were contacted and Dr Gregory was approached to be the Master Clinician for the clinical lectures and demonstrations in the afternoon. Dr Gregory was kind enough to accept our invitation. He was then asked to detail the instruments/ burs required

for the procedures and any other requirements he had.

It was also necessary to arrange a number of tutors for the Course and we approached ten colleagues, five from Greece and five from Australia for this. All accepted our invitation and we were very pleased to have ten experienced colleagues committing themselves for the Course. We were also glad to have six young Greek dentists who assisted the tutors as well as the attendees in their work.

The initial aim of the Course was that it was to be low cost and attract practitioners who had had limited access to more advanced paediatric restorative techniques in their basic training. We were looking at practitioners from eastern Europe and Africa in particular.

The Course outline included a morning of didactic instruction covering common paediatric dental topics – local anaesthesia, rubber dam, pulp therapy and exodontia followed by an afternoon of clinical training. This included a lecture on primary crown preparation (anterior strip crowns and posterior SSC) followed by a “live” broadcast of Dr Gregory preparing the various crowns and pulpotomy. The attendees then had a supervised phantom head, laboratory exercise to practise these techniques. Plastic teeth were used for the crowns and extracted primary teeth were used for the pulpotomy.

The months preceding the Congress were very hectic for Dr Gizani. However I cannot congratulate her enough on the excellent preparations she had made for the Course. The number of candidates enrolled was thirty-six, a limit imposed by the size of the laboratory. The number of instruments and the amount of ancillary materials was enormous. It took a lot of patient organising and Dr Gizani went about this task with good humour and grace. As well Dr Gregory was kind enough to arrange for the appropriate rubber dam clamps and burs which he carried to Greece for the Course.

On the Day!

There was much nervous energy in the air as we all gathered early in the morning of 15th June in the Dental School foyer. The attendees received their Course material and the lectures got under way. At the first morning tea break the general mood was very positive and this continued on through the morning to lunch. The morning lectures were all excellent and very well received.

The afternoon began with Dr Gregory’s lecture, followed by his clinical demonstration. Dr Gregory had spent all morning with Mr Pavlos Tripodakis and the audio-visual technicians getting everything perfect. Peter had to learn to work within the camera view but keep out of the camera’s way as much as he could. Peter worked very hard through this time and he was absolutely ready for immediate take off in the afternoon!!

The laboratory was a buzz with people, television screens, clinking instrument and the voices of many nations. It was a great experience as tutors provided guidance, attendees prepared their crowns and Dr Gregory, soared above everyone, like Zeus with a microphone, whilst cajoling all to “get it right”.

I could go on with all the experiences we had on the day but suffice to say it was a fantastic experience for all, but especially the attending dentists who learned so much.

Sponsors

The ANZSPD very generously agreed to underwrite this Course and both Dr Gizani and I were very grateful for this terrific support. It was a very significant cost to the Society and was greatly appreciated by not only all whom attended but by the broader community of the IAPD as well. The sponsorship certainly was a talking point and the contribution to the success of the Congress cannot be underestimated.

Whether such a role will be played again by the ANZSPD is not guaranteed,

however I strongly believe it is worthy of serious consideration if the opportunity arises again.

3M

We would like to thank the generous support of 3M in providing very considerable amount of restorative materials and all the crowns required for the Course. This was absolutely crucial and their involvement was crucial to the success of the day. In particular we would like to thank Dr Sigrid Hader. She attended the whole day and was very interested in all the suggestions that were made re the crowns. We are also grateful to the Ivoclar-Vivadent Company for their generous support in providing much of the dental materials necessary for the training course. It was a pleasure to have their representative Dr Tatiana Repetto-Bauchhage attend the course.

Summary

The Pre-Congress "Hands-on" course held in Athens as part of the IAPD 25th Congress was very successful. There were many lessons learnt both from the organisational side as well as from the actual day. We would certainly recommend that any future hands-on courses should have a separate registration fee, as this would help guarantee attendance. It would not have to be expensive, something in the order of 30 to 40 Euros would be sufficient.

We would both like to add our personal thanks to all the Lecturers, Tutors, Dr P Gregory, Sponsors and of course all those who attended without whom we would not have had a Course. Finally we both would like to put on the record our respect and admiration for Prof L Papagiannoulis and the LOC, but especially Prof Papagiannoulis for holding what was the best ever IAPD Congress. We were proud to be part of it.

List of Attendees at Pre Congress Course Athens IAPD June 2011

PRE-CONGRESS	COUNTRY
Basic Paediatric Dentistry Clinical Procedures	ARGENTINA
Basic Paediatric Dentistry Clinical Procedures	BELGIUM
Basic Paediatric Dentistry Clinical Procedures	BELGIUM
Basic Paediatric Dentistry Clinical Procedures	BRAZIL
Basic Paediatric Dentistry Clinical Procedures	BRAZIL
Basic Paediatric Dentistry Clinical Procedures	BRAZIL
Basic Paediatric Dentistry Clinical Procedures	BULGARIA
Basic Paediatric Dentistry Clinical Procedures	CHINA
Basic Paediatric Dentistry Clinical Procedures	CHINA
Basic Paediatric Dentistry Clinical Procedures	CHINA
Basic Paediatric Dentistry Clinical Procedures	CROATIA
Basic Paediatric Dentistry Clinical Procedures	GREECE
Basic Paediatric Dentistry Clinical Procedures	GREECE
Basic Paediatric Dentistry Clinical Procedures	INDIA
Basic Paediatric Dentistry Clinical Procedures	INDIA
Basic Paediatric Dentistry Clinical Procedures	INDIA
Basic Paediatric Dentistry Clinical Procedures	INDONESIA
Basic Paediatric Dentistry Clinical Procedures	INDONESIA
Basic Paediatric Dentistry Clinical Procedures	INDONESIA
Basic Paediatric Dentistry Clinical Procedures	INDONESIA
Basic Paediatric Dentistry Clinical Procedures	MALAYSIA
Basic Paediatric Dentistry Clinical Procedures	MEXICO
Basic Paediatric Dentistry Clinical Procedures	NIGERIA
Basic Paediatric Dentistry Clinical Procedures	NIGERIA
Basic Paediatric Dentistry Clinical Procedures	RUSSIA
Basic Paediatric Dentistry Clinical Procedures	SAUDI ARABIA
Basic Paediatric Dentistry Clinical Procedures	SERBIA
Basic Paediatric Dentistry Clinical Procedures	SOUTH AFRICA
Basic Paediatric Dentistry Clinical Procedures	SOUTH KOREA
Basic Paediatric Dentistry Clinical Procedures	SUDAN
Basic Paediatric Dentistry Clinical Procedures	SUDAN
Basic Paediatric Dentistry Clinical Procedures	SWITZERLAND
Basic Paediatric Dentistry Clinical Procedures	UK
Basic Paediatric Dentistry Clinical Procedures	UK
Basic Paediatric Dentistry Clinical Procedures	UNITED ARAB EMIRATES
Basic Paediatric Dentistry Clinical Procedures	UNITED ARAB EMIRATES



The Athens University Dental School



The laboratory set up and ready to go. Each phantom head was given a name of either a past ANZSPD or Hellenic Paed Dentistry Society President !



Several of the African participants enjoying their clinical session



Co-Convenor, Dr Sotiria Gizani providing sound advice to one of the attendees



"Master Clinician", Dr Peter Gregory getting ready to perform-aka Zues with a microphone !



Dr Sotiria Gizani, Dr Katerina Kavvadia, Dr Tatiana Bauckhage share a moment at the end of the day



Dr Gregory demonstrating crown preparation



*Drs John Winters and Jamie Lucas clarifying a point
s about anterior crown preparation*



Dr Sotiria Gizani and Dr Sigrid Hader

ANZSPD – RK Hall Travelling Lecture Series ULURU 2011

P. Joe W. Verco
Paediatric Dentist and Convenor

The R. K. Hall Travelling Lecture Series is a biennial conference of the Australian and New Zealand Society of Paediatric Dentistry. It was held this year in August at Uluru, coinciding with the 100th Anniversary of the Northern Territory.

Delegates came from as far away as USA – (Alaska, Utah and Washington State), Canada, Germany as well as New Zealand and from all over Australia. As the convenor, promotion of the Lecture Series relied mainly on E-News of the American Academy of Paediatric Dentistry, the European Academy of Paediatric Dentistry and the Royal Australasian College of Dental Surgeons.

Pre-Conference Tour

Many delegates took advantage of the pre-conference tour to visit Alice Springs and the Western MacDonnell Ranges. Of interest in Alice Springs were the Royal Flying Doctor Service, The Overland Telegraph Station, and the Mbantua Gallery of indigenous art and artefacts.

The tour of the Western MacDonnell Ranges included Simpson's Gap, Standley Chasm, Ormiston Gorge and Glen Helen Station. This year was most notable for the abundant vegetation due to the unusually heavy rains over the past year.

On the final morning prior to flying to Uluru, the delegates were treated to a champagne flight of 16 km by hot air balloon, and later a visit to The School of the Air – which turned 60 years old this year.

Conference

Prof. Joel Berg, President Elect of the American Academy of Paediatric Dentistry, was the keynote speaker. He shared his insight into early preventive treatment and the method to achieve behavioural change in children, their parents and dentists.

Programme: As easy as ABCD!

Access to Baby and Child Dentistry (ABCD) will change the pattern of dental practise for general dentists. It features a child's first dental appointment at age 1; early examination, education of the mother (frequency of sucrose intake, demineralization, caries recognition) and frequent monitoring. Its greatest benefit is likely to assist the socially disadvantaged. In Australia this may be significant as School Dental Clinics are to be discontinued in favour of "Super Clinics."

The speakers included: A/Prof Roger Hall O.A.M.; Dr. Jamie Robertson A.M.; Dr. Eduardo Alcaino, President, The International Association of Paediatric Dentistry; Prof. Nigel King, President, Australian Academy of Paediatric Dentistry; Prof. David Manton, Elsdon Storey Chair of Child Dental Health, University of Melbourne; A/Prof Angus Cameron, Registrar Special Stream, Royal Australasian College of Dental Surgeons; and Dr. Kareen Mechertician, President, ANZSPD.

In addition to Caries Management in Early Childhood, topics included; "Paediatric Dentistry in the Northern Territory," "Towards a Normal Child with Normal Teeth," "Supernumerary Teeth," "Molar Incisor Hypomineralisation," "General Anaesthesia in Paediatric Dentistry," "Paediatric Dentistry's Moral Compass," "Long Q-T Syndrome," and "The Rotary Australia – Vietnam Dental Health Project."

Social Events

Beyond the Conference, the Social Calendar was outstanding – "Sounds of Silence" a gourmet buffet in the desert under the stars. The Milky Way, on the moonless night, was awesome. It would rate as one of the top one hundred "must do" before passing to the afterlife! Sunset at Kata Tjuta – another unforgettable experience of nature, again in style with a glass of red or champagne!

My gratitude to colleagues who gave their time to make this so special, whether as organisers or delegates. A special thank you to our generous sponsors, COLGATE – our major sponsor, DMG, GUNZ and SDI for your continued support that made it possible.

ANZSPD – RK Hall Travelling Lecture Series ULURU 2011 – Opening Address

Convenor PJW Verco

We acknowledge the Anangu people of the APY Lands – in particular the Community of Mutitjulu.

Welcome to the RK Hall Travelling Lecture Series – for the first time stationary in the Centre of Australia- ULURU in the 100th Year of the Northern Territory and celebrating the 50th Year of its emblem, the Territory Rose.

The Programme is crowded with talent, experience, and good humour.

We welcome our Guest Speaker **Prof. Joel Berg** from Washington State and congratulate him on his new Paediatric Dental Department.

A/Prof. Roger Hall OAM, after whom the Lecture Series was named, thank you for being part of the programme – I didn't realize that you had "Never Never Been Before". As an aside thank you for being a driving force of ANZSPD, a mentor, friend and colleague, It was an honour to be part of your Inauguration in Melbourne – which you shared with John Farnham. I still remember the fish and chips and a bottle of Grange in the Melbourne Club for Luncheon.

Dr Eduardo Alcaino, the new President of the International Association of Paediatric Dentistry. Ed thank you for allowing us to pressure you into coming. Quite often Australians only get recognition in overseas countries and lastly in Australia – Ed I hope we have reversed this.

Dr Jamie Robertson AM, not only congratulations upon your Australian Award this year but also we recognize you for constant hard work and enthusiasm within the profession. You have always been a diplomat and kept on diligently chipping away. Thank you for coming and we look forward to your lecture.

Prof. Nigel King as President of The Australasian Academy of Paediatric Dentistry welcome to a new life in Perth W.A. and thank you for coming. We are told that your second home is in Margaret River!

Prof. David Manton the new Prof. of the Elsdon Storey Chair of Child Dental Health in Melbourne. Thank you for coming to the wide open spaces of Australia. Thank you also for rounding up the post-grads and mentoring a few older ferals to come as well. We take the opportunity of welcoming you all.

A/Prof Angus Cameron Registrar of Special Fields Royal Australasian College of Dental Surgeons from Westmead now leads a team to treat children in the outback. Angus is a well regarded International academic and is responsible for the Special Stream in the Royal Australasian College of Dental Surgeons. Angus has always been good at mentoring students as well as colleagues. Angus thank you for coming.

Dr Kareen Mechertician the President of ANZSPD Federally, Kareen thank you for squeezing \$ from Colgate to help us put on this and other meetings for the next 5 years.

Dental Industry

COLGATE

with Lenore Tuckerman and Dr Sue Cartwright – thank you for your continued support – particularly when we have a clinical component to an academic meeting. Thank you, this is hopefully the first of many and adds a new dimension to our exposure to the Aboriginal Population – even if it is only in a small way.

Other support from the Dental Industry we acknowledge: **DMG – Michael Grant; GUNZ DENTAL – Roseanne Ochremienko; SDI – Thomas Cheetham.**

OVERSEAS

We welcome colleagues from USA, CANADA, GERMANY.

ORGANISING COMMITTEE

Wendy CHEUNG "in absentia"

Michael MALANDRIS

Helen MCLEAN

Dean HEWLETT

John CAMERON

Laura BIRCHBY – The Meeting People

I thank you for diligent hard work and look forward to the fruits of our labour.

Innovations

- September 2009 DUST STORM over SYDNEY, just to let those on the other side of the Great Divide know that there was a drought.
- MONTHLY MISSIVE – 100 yrs NT
– 50 yr Territory Rose.
– We sent Monthly Missives from Aug 2010 in order to get enthusiasm.
- Conference Booklet – Notes can be made opposite each speaker – Synopses.
- "Outback" – Aug/Sept Edition – featured Ayers Rock.
- Vegemite (2 sachets each).
- Sunscreen (30+).
- RFDS Hat – (RFDS is 83 in 2011)

Our final Seminar may prove to be fruitful in that regard, as there is to be a National Rural Health Conference in 2013 in Adelaide.

Post Conference Comment: Prof Joel Berg will lead a delegation through People to People Programme (ptpi.org) to South America.

Member (Am) In The General Division Of The Order Of Australia

Emeritus Professor Louise Brearley MESSER

No doubt many of our members will have heard the wonderful news of Professor Louise Brearley Messers' recent award of Member (AM) the General Division of the Order of Australia in the Australia Day honours list

I have formally written to LBM congratulating her on behalf of the Executive and entire membership. We are in the process of arranging an opportunity in Canberra to help commemorate this event and allow Professor Brearley a chance to also speak to the members. I would like to also thank all those behind the scenes in helping to achieve this for Professor Brearley ... Alistair and Joe in particular.

Kareen Mekertichian

Member (Am) In The General Division Of The Order Of Australia

Emeritus Professor Louise Brearley MESSER, Vic_For service to the dental profession, particularly in the field of paediatric dentistry, as a clinician, academic and researcher.

Elsdon Storey Professor of Child Dental Health, Department of Conservative Dentistry, School of Dental Science, University of Melbourne, 1990-2008; Director of Continuing Education, 1996-1998; Director of Graduate Studies, 1997-2008; Lecturer.

Honorary Consultant, Royal Children's Hospital, Melbourne, 1990-2008.

Lecturer, Dental Health Services Victoria, since 1990._Lecturer, Department of Oral Biology, School of Dentistry, University of British Columbia, Vancouver, Canada, 1972-1974._Researcher and Lecturer, Department of Paediatric Dentistry, University of Minnesota, Minneapolis, USA, 1974-1989; Research Thesis Supervisor and Examiner.

President, Australasian Academy of Paediatric Dentistry, mid 1995; Foundation Vice-President, 1989-1995._Examiner, Royal Australasian College of Dental Surgeons, since 1996._Examiner, Overseas Trained Dentist examinations, Australian Dental Examining Council, 1994-2000.

Committee Member of various committees, Victorian Branch, Australian Dental Association; Consultant on Water Fluoridation._Member of the International Association for Dental Research, the American Academy of Pediatric Dentistry, the Australian Nutrition Foundation, the Australian and New Zealand Society of Paediatric Dentistry, and the Victorian Women Dentists' Association.

Editorial Board Member, Dental Traumatology, Pediatric Dentistry, since 1999. Author and contributor of numerous articles, reports and book chapters.

Appointed Fellow, Royal Australasian College of Dental Surgeons, 2003. Fellow, International College of Dentists.

Awards/recognition include:_Distinguished Service Award, Australian Dental Association, 2011._Alan Docking Research Award, ANZ Division, International Association for Dental Research, 2007._Leadership Award, Victorian Women Dentists' Association, 2005._The W T Smith Teaching Award, School of Dental Science, University of Melbourne, 2003.

Western Australia Branch

The end of 2011 and beginning of 2012 has been a particularly busy time for the WA Branch. At the end of September, a most successful “Dental Trauma Symposium” was held at the University of WA Club on the main campus of the University. This meeting was held in association with the WA Branch of the Australian Society of Endodontology and the meeting proved to be a great success. Over 200 people registered to attend and they were taken through, in a systematic manner, aspects of trauma to the primary and permanent dentitions and associated soft tissues. This included a comprehensive consideration of immediate management, both short and long term follow up and also prevention. The program was delivered by a panel of speakers drawn from the memberships of both Societies. The overall co-ordination of the day was in the hands of an ANZSPD (WA Branch) Committee member, Dr Yee Sang Welten. That the day was such a success was in no small way due to Yee Sang’s tireless efforts and close attention to detail.

A fortnight later the Branch held its Annual General Meeting and Dinner, once again at the University of Western Australia Club. There were two special guests: Professor David Manton delivered a most thought provoking after dinner talk on the future of post-graduate study and research in paediatric dentistry in Australia. The other special guest was the newly appointed Professor of Paediatric Dentistry at the University of Western Australia, Winthrop Professor Nigel King, formerly of Hong Kong. Professor King will be well known to many A.N.Z.S.P.D. members already! The Annual General Meeting saw the re-election of the same executive, with Dr Carmel Lloyd re-elected Branch President, Dr Alistair Devlin re-elected Secretary-Treasurer and Dr Tim Johnston re-elected as Federal Councillor.

There has been an early start to the 2012 program. The Australian Society of Orthodontists has held its 23rd Convention in Perth in February 2012, and so the Branch was most fortunate to have one of the keynote Speakers of that Convention, Professor Lysle Johnston, come along to a Dinner Meeting and provide an after dinner talk. His chosen topic was: “Alchemy Redux: Wishful Thinking in the Treatment of Crowding and Protrusion”. It was a fascinating look at the continuing debate on the place of extractions in orthodontics from an eminently qualified speaker - Professor Johnston is both Professor Emeritus of Dentistry at the University of Michigan and Professor Emeritus of Orthodontics at the St Louis University in Missouri.

The next meeting of the branch will be the annual country meeting. Once again, this will be held at the magnificent Bunker Bay Resort in the south west of the state. The very special guest and speaker will be the Federal President of A.N.Z.S.P.D., Dr Kareen Mekertichian. Kareen has chosen a tempting topic, “The Life Cycle of a Decayed Molar – The First Primary Molar and the First Permanent Molar”.

Alistair Devlin

Victoria Australia Branch

The ANZSPD Victorian branch held their annual Elsdon Storey Memorial Lecture on the 25th of October, 2011 at the Quality Resort All Seasons in Bendigo. This successful event was jointly held with the Australian Dental Association Northern Group and well attended. The theme for the day was ‘Early Childhood Caries’ with a high calibre of presentations given by all speakers. Dr Kerrod Hallet, Head of the Department of Paediatric Dentistry at the Royal Children’s Hospital presented on ‘Caries management by risk assessment’. The ANZSPD national President, Dr Kareen Mekertichian discussed ‘Restorative considerations in the management of early childhood caries’ and ‘Extractions- a valid consideration in early childhood caries’. The ‘Challenges to better preschool dental health’ was presented by Associated Professor Mark Gussy and Dr Rebecca Williams discussed management of a patient with ‘Premature exfoliation of primary teeth’. Dr Chris Olsen provided a very moving address to Dr Elsdon Storey detailing his contributions and dedication to dental education and our profession.



The next Victorian Branch meeting will be held on Saturday 25th of February 2012 on the theme of “Understanding Autism”. In 2012 the Elsdon Storey Memorial Lecture and Annual General Meeting will be held on Saturday 20th of October 2012. The theme for this day is “Treatment planning- same case, different perspectives”.

Alistair Devlin



Look who's back!

Australia and New Zealand Society of Paediatric Dentistry Biennial Conference

Friday 20 July - Saturday 21 July 2012

Opening ceremony Thursday 19 July (evening)

Hotel Realm, Canberra

Principal Sponsor: **Colgate**

Conference Guest Speaker: Professor Christopher Deery
Professor of Paediatric Dentistry, University of Sheffield, UK



PLUS...

A wonderful lineup of speakers have been arranged, a terrific venue
and accommodation at the Hotel Realm,
and a memorable conference dinner at the National Portrait Gallery.

Mark this date in your diary!



To receive further updates on the conference, please contact the Conference Organiser,
ADA NSW Centre for Professional Development at ANZSPD2012@adacpd.com.au or call 1800 737 346.

www.anzspd.org.au

26 MAY 2011

Colgate® Corner

by Sue Cartwright, BDS, Dip Clin Dent, M Ed



Healthy Smiles

Oral Health & Fluoride Varnish Training Program for Primary Health Care Workers

To help improve oral health in remote communities Colgate provided educational funding and materials to the Northern Territory Government for the development of an Oral Health and Fluoride Varnish Training Program.

The Northern Territory is largely made up of small, remote communities without water fluoridation

- Children in the Northern Territory have poorer oral health than anywhere else in Australia. The Child Dental Health Survey 2003-4 showed that 5-6 year old Territorians have the highest average total number of teeth with experience of dental decay.
- Menzies School of Health Research Strong Teeth for Little Kids was a randomised controlled trial, conducted in the Northern Territory (NT) from 2006-08. The study showed a 24-36% reduction in tooth surfaces developing dental caries over 2 years, with 6 monthly applications of Duraphat.
- Healthy Smiles – Oral Health & Fluoride Varnish Training Program for Primary Health Care Workers has been developed by the Northern Territory Government with assistance from Colgate.
- Programme materials can be accessed at http://www.health.nt.gov.au/Oral_Health/Oral_Health_Promotion/index.aspx



Armfield, J.M., Spencer, A.J., & Brennan, D.S. (2009). Dental health of Australia's teenagers and pre-teen children: The child dental health survey, Australia 2003-4, Dental Statistics and Research Series no.52. Cat. no. DEN199. Canberra: AIHW
Menzies School of Health Research(2006-2008) Strong Teeth for Little Kids Project

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Coming Events

24-27 May 2012

65th AAPD Annual Session

San Diego, USA

www.aapd.org

19th July 2012

AAPD General Meeting

Canberra, Australia

aapdaustralia@y7mail.com

19-21st July 2012

ANZSPD Biennial Conference 2012

Canberra, Australia

ANZSPD@adacpd.org.au

29 August-1 September 2012

FDI Congress

Hong Kong, SAR

www.fdiworldental.org

28 – 31st October 2012

21st Congress of the international Association for Disability and Oral health

Melbourne, Australia

www.iadh2012.com

19 April 2013

8th EAPD Interim Seminar and Workshop

Cyprus

Contact: webmaster@eapd.eu

www.eapd.gr

24-27 May 2013

66th AAPD Annual Session

Orlando, Florida, USA

www.aapd.org

12-15 June

IAPD International Congress

Seoul, Korea

www.iapdworld.org

22-25 May 2014

67th AAPD Annual Session

Boston, Mass. USA

www.aapd.org

28 May-1 June 2014

12th EAPD Congress

Sopot, Poland

Contact: webmaster@eapd.eu

www.eapd.gr

Australia and New Zealand Society of Paediatric Dentistry
www.anzspd.org.au

Federal President

Dr Kareen Mekertichian

ksmekj@bigpond.net.au

Federal Secretary Mgr

Dr Alistair Devlin

devlins@inet.net.au

Immediate Past President

Dr Nina Vasan

nvasan@xtra.co.nz

Branch

President

Secretary

Fed Councillor

NSW

A/Prof Richard Widmer
richardW@chw.edu.au

Dr Anna Sanares
annas@dentalpx.com.au

Dr Kareen Mekertichian
ksmek@bigpond.net.au

QLD

A/Prof W Kim Seow
k.seow@uq.edu.au

Dr Steve Kazoullis
kazoullis@pdgdental.com.au

Dr Vivienne Linnett
vlinnett@bigond.net.au

SA

Dr PJW Verco
joverco@verco.com.au

Dr Wendy Cheung
wendywsc@hotmail.com

Dr PJW Verco
joverco@verco.com.au

VIC

Dr Margarita Silva
drmsilva@bigpond.net.au

Fiona Ng
prodontome@inet.net.au

Dr John Sheahan
johnsheahan@bigpond.com

WA

Dr Kate Dyson
kdyson@meddent.uwa.edu.au

Dr Alistair Devlin
devlins@inet.net.au

Dr Tim Johnston
timjohnston@westnet.com.au

NZ

Dr Mary Anne Costello
maryannecos@xtra.co.nz

Craig Waterhouse
craig.shona@xtra.co.nz

Dr Katie Myers
katie.ayers@mac.com

Editor Synopses

Timothy Johnston

timjohnston@westnet.com.au

Correspondence

Timothy Johnston

The Editor, Synopses

8 Thelma Street

West Perth WA 6005

AUSTRALIA

Printing and distribution

Colgate®

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Level 15, 345 George Street

Sydney NSW 2000 AUSTRALIA

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Submissions

All text for inclusion in Synopses must be submitted to the editor on CD or by email. Media will not be returned. Address email to timjohnston@westnet.com.au. Please enclose your contact details and email address with all submissions.

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